



House Bill No. 6868

Public Act No. 15-171

**AN ACT CONCERNING THE CONNECTICUT INSURANCE
GUARANTY ASSOCIATIONS.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivisions (5) and (6) of section 38a-838 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(5) (A) "Covered claim" means an unpaid claim, including, but not limited to, one for unearned premiums, [which] that arises out of and is within the coverage and subject to the applicable limits of an insurance policy to which sections 38a-836 to 38a-853, inclusive, apply, [issued by an insurer,] if such insurer becomes an insolvent insurer [after October 1, 1971, and (A)] or such claim was assumed as a direct obligation by an insurer that becomes an insolvent insurer, where such obligation was assumed through a merger or an acquisition, pursuant to an acquisition of assets and assumption of liabilities or pursuant to an assumption reinsurance transaction, and (i) the claimant or insured is a resident of this state at the time of the insured event, [; or (B)] or (ii) the claim is a first party claim for damage to property with a permanent location in this state. [provided the term "covered claim" shall] For the purposes of this subparagraph, the residence of a claimant or an insured that is not an individual shall be the state in

House Bill No. 6868

which such claimant's or insured's principal place of business is located at the time of the insured event.

(B) "Covered claim" does not include (i) any claim by or for the benefit of any reinsurer, insurer, insurance pool [,] or underwriting association, as subrogation recoveries or otherwise, [;] provided [that] a claim for any such amount, asserted against a person insured under a policy issued by an insurer [which] that has become an insolvent insurer, [which] that, if it were not a claim by or for the benefit of a reinsurer, insurer, insurance pool or underwriting association, would be a "covered claim", may be filed directly with the receiver of the insolvent insurer but in no event shall any such claim be asserted against the insured of such insolvent insurer, (ii) any claim by or on behalf of an individual who is neither a citizen of the United States nor an alien legally resident in the United States at the time of the insured event, or an entity other than an individual whose principal place of business is not in the United States at the time of the insured event, and it arises out of an accident, occurrence, offense, act, error or omission that takes place outside of the United States, or a loss to property normally located outside of the United States or, if a workers' compensation claim, it arises out of employment outside of the United States, (iii) any claim by or on behalf of a person who is not a resident of this state, other than a claim for compensation or any other benefit [which] that arises out of and is within the coverage of a workers' compensation policy, against an insured whose net worth at the time the policy was issued or at any time thereafter exceeded twenty-five million dollars, provided [that] an insured's net worth for purposes of this section and section 38a-844 shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis, (iv) any claim by or on behalf of an affiliate of the insolvent insurer at the time the policy was issued or at the time of the insured event, [or] (v) any claim arising out of a policy issued by an insurer [which] that was not licensed to transact

House Bill No. 6868

insurance in this state [either] at the time the policy was issued, when it assumed the obligation for the covered claim or when the insured event occurred, (vi) any amount due under any policy originally issued by a surplus lines carrier, risk retention group, self-insurer or group self-insurer, (vii) any obligation assumed by an insolvent insurer after the commencement of any delinquency proceeding, as defined in section 38a-905, involving the insolvent insurer or the original insurer, unless it would have been a covered claim absent such assumption, or (viii) any obligation assumed by an insolvent insurer in a transaction in which the original insurer remains separately liable;

(6) "Insolvent insurer" means an insurer (A) (i) licensed to transact insurance in this state [either] at the time the policy was issued, when it assumed the obligation for the covered claim or when the insured event occurred, and (ii) [determined to be insolvent] against which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the insurer's state of domicile; (B) [which] that is (i) the legal successor of an insurer that was licensed to transact insurance in this state either at the time the policy was issued or when the insured event occurred, by reason of a merger, provided such merger is approved by an insurance regulator having jurisdiction over such merger, and (ii) [determined to be insolvent] against which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the insurer's state of domicile; or (C) [which] that (i) succeeds to the policy obligations of an insurer that was licensed to transact insurance in this state either at the time the policy was issued or when the insured event occurred, by reason of a division whereby policies issued by such licensed insurer are transferred to an insurer, [and (ii) is determined to be insolvent by a court of competent jurisdiction,] provided such division is approved (I) in a jurisdiction that allows such division, and (II) by an insurance regulator having jurisdiction over such division, and (ii) against which a final order of liquidation with a finding of

House Bill No. 6868

insolvency has been entered by a court of competent jurisdiction in the succeeding insurer's state of domicile. "Insolvent insurer" shall not be construed to mean any insurer with respect to which an order, decree, judgment or finding of insolvency, whether permanent or temporary in nature, or order of rehabilitation or conservation has been issued by a court of competent jurisdiction prior to October 1, 1971;

Sec. 2. Subsection (a) of section 38a-841 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) Said association shall:

(1) Be obligated to the extent of the covered claims existing prior to the determination of insolvency or the entry of a final order of liquidation with a finding of insolvency, as applicable, and arising within thirty days after the determination of insolvency or the entry of such order, or before the policy expiration date if less than thirty days after the determination or the entry of such order, or before the insured replaces the policy or causes its cancellation [, if he] if the insured does so within thirty days [of] after such determination or entry of such order, provided such obligation shall be limited as follows: (A) With respect to covered claims for unearned premiums, to one-half of the unearned premium on any policy, subject to a maximum of two thousand dollars per policy; (B) with respect to covered claims other than for unearned premiums, such obligation shall include only that amount of each such claim [which] that is in excess of one hundred dollars and is less than (i) three hundred thousand dollars for claims arising under policies of insurers determined to be insolvent prior to October 1, 2007, [and] (ii) four hundred thousand dollars for claims arising under policies of insurers determined to be insolvent on or after October 1, 2007, [except that said] and prior to October 1, 2015, and (iii) five hundred thousand dollars for claims arising under policies of insurers against which a final order of liquidation with a

House Bill No. 6868

finding of insolvency has been entered by a court of competent jurisdiction in the insurer's state of domicile on or after October 1, 2015. Said association shall pay the full amount of any such claim arising out of a workers' compensation policy, provided in no event shall said association be obligated [(i)] (I) to any claimant in an amount in excess of the obligation of the insolvent insurer under the policy form or coverage from which the claim arises, or [(ii)] (II) for any claim filed with the association after the expiration of two years from the date of the declaration of insolvency unless such claim arose out of a workers' compensation policy and was timely filed in accordance with section 31-294c;

(2) [be] Be deemed the insurer to the extent of its obligations on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent;

(3) [allocate] Allocate claims paid and expenses incurred among the three accounts, created by section 38a-839, separately, and assess member insurers separately (A) in respect of each such account for such amounts as shall be necessary to pay the obligations of said association under subdivision (1) of this subsection subsequent to an insolvency; (B) the expenses of handling covered claims subsequent to an insolvency; (C) the cost of examinations under section 38a-846; and (D) such other expenses as are authorized by sections 38a-836 to 38a-853, inclusive. The assessments of each member insurer shall be in the proportion that the net direct written premiums of such member insurer for the calendar year preceding the assessment on the kinds of insurance in such account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in such account. Each member insurer shall be notified of its assessment not later than thirty days before it is due. No member insurer may be assessed in any year on any account an

House Bill No. 6868

amount greater than two per cent of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in said account, provided if, at the time an assessment is levied on the all other insurance account, as defined in subdivision (3) of section 38a-839, the board of directors finds that at least fifty per cent of the total net direct written premiums of a member insurer and all its affiliates, for the year on which such assessment is based, were from policies issued or delivered in Connecticut, on risks located in this state, such member insurer shall be assessed only on such member insurer's net direct written premium that is attributable to the kind of insurance that gives rise to each covered claim. If the maximum assessment, together with the other assets of said association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available may be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. Said association may defer, in whole or in part, the assessment of any member insurer [.] if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance, provided [that] during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when such payment will not reduce capital or surplus below the minimum amounts required for a certificate of authority. Such payments shall be refunded to those insurers receiving greater assessments because of such deferment or, at the election of the insurer, be credited against future assessments. Each member insurer serving as a servicing facility may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by such member insurer if they are chargeable to the account in respect of which the assessment is made;

House Bill No. 6868

(4) [investigate] Investigate claims brought against said association and adjust, compromise, settle, and pay covered claims to the extent of said association's obligations [,] and deny all other claims. The association shall pay claims in any order it deems reasonable including, but not limited to, payment in the order of receipt or by classification. It may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested;

(5) [notify] Notify such persons as the commissioner may direct under subdivision (1) of subsection (b) of section 38a-843, as amended by this act;

(6) [handle] Handle claims through its employees or through one or more insurers or other persons designated by said association as servicing facilities, provided such designation of a servicing facility [shall be subject to the approval of] is approved by the commissioner [,] and may be declined by a member insurer;

(7) [reimburse] Reimburse each such servicing facility for obligations of said association paid by such facility and for expenses incurred by such facility while handling claims on behalf of said association and shall pay such other expenses of said association as are authorized by sections 38a-836 to 38a-853, inclusive.

Sec. 3. Subsections (a) and (b) of section 38a-843 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) The commissioner shall: (1) Notify said association of the existence of an insolvent insurer, and notify the chairman of the Workers' Compensation Commission and the State Treasurer of the existence of an insolvent workers' compensation insurer, not later than

House Bill No. 6868

three days after [he] the commissioner receives notice of [the determination of] any such insolvency; (2) upon request of the board of directors, provide said association with a statement of the net direct written premiums of each member insurer.

(b) The commissioner may: (1) Require that said association notify those persons insured by the insolvent insurer, and any other interested parties, of the [determination] entry of a final order of liquidation with a finding of insolvency and of their rights under sections 38a-836 to 38a-853, inclusive. Such notification shall be by mail sent to their last known address, where available, provided if sufficient information for such notification by mail is not available, notice by publication in a newspaper of general circulation shall be sufficient to satisfy the requirements of this subsection; (2) suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or which fails to comply with said plan of operation. In lieu of such suspension or revocation, the commissioner may levy a fine on any member insurer [which] that fails to pay an assessment when due, provided no such fine shall exceed five per cent of the unpaid assessment per month, and provided no fine shall be less than five hundred dollars per month; (3) revoke the designation of any servicing facility if the commissioner finds claims are being handled unsatisfactorily.

Sec. 4. Subsection (f) of section 38a-860 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(f) (1) Sections 38a-858 to 38a-875, inclusive, shall provide coverage to the persons specified in subsections (a) to (d), inclusive, of this section for direct, nongroup life, health or annuity policies or contracts and supplemental contracts to such policies or contracts, for certificates under direct group policies and contracts, and for unallocated annuity

House Bill No. 6868

contracts issued by member insurers, except as limited by said sections. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries and any immediate or deferred annuity contracts.

(2) [Said sections] Sections 38a-858 to 38a-875, inclusive, shall not provide coverage for: (A) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder; (B) any policy or contract of reinsurance, unless assumption certificates have been issued; (C) any portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value (i) averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, exceeds the rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier, [;] and (ii) on and after the date on which the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available; (D) a portion of a policy or contract issued to any plan or program of an employer, association or similar entity to provide life, health or annuity benefits to its employees or members to the extent that such

House Bill No. 6868

plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association or similar entity under (i) a multiple employer welfare arrangement as defined in Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended from time to time, [;] (ii) a minimum premium group insurance plan, [;] or (iii) an administrative services only contract; (E) any stop-loss or excess loss insurance policy or contract providing for the indemnification of or payment to a policy owner, a contract owner, a plan or another person obligated to pay life, health or annuity benefits; (F) any portion of a policy or contract to the extent that it provides dividends, experience rating credits, voting rights or provides that any fees or allowances be paid to any person, including, but not limited to, the policy or contract holder, in connection with the service to or administration of such policy or contract; (G) any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state; (H) any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan; (I) any portion of an unallocated annuity contract that is not issued to, or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery; (J) any subscriber contract issued by a health care center; (K) a contractual agreement that establishes the insurer's obligation by reference to a portfolio of assets that is not owned or possessed by the insurance company; (L) an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including, but not limited to, [; (i) A] (i) a claim based on marketing materials, [;] (ii) a claim based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements, [;] (iii) a misrepresentation of or regarding

House Bill No. 6868

policy benefits, [;] (iv) an extra-contractual claim, [;] or (v) a claim for penalties or consequential or incidental damages; (M) a contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer; [and] (N) a portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but [which] that have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subparagraph, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and shall not be subject to forfeiture; and (O) any policy or contract providing hospital, medical, prescription drugs or other health care benefits pursuant to Part C, 42 USC 1395w21 et seq., or Part D, 42 USC 1395w101 et seq., as both may be amended from time to time, or any regulations issued thereunder.

Approved July 2, 2015